

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LA PLATA (RURAL)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X LA PLATA (RURAL)</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>M.</b> Last <b>BAILEY</b>				4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>1962</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 18, 1907</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>22</b> Min.		IF UNDER 24 HRS. Months <b>5</b> Days <b>19</b> Hours <b>22</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEMUEL DODSON</b>				14. MOTHER'S MAIDEN NAME <b>CORA CHUN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>MASCELIA GRAY, LA PLATA, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 3-1-62</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <b>Hilltop, Maryland</b>				DATE SIGNED <b>3-5-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-9-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ZION BAPTIST</b>		22d. LOCATION (City, town, or country) (State) <b>Hilltop, Maryland</b>	
23. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME, WADSWORTH, MD.</b>				24a. REC'D BY REGISTRAR <b>MAR 12 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

MEDICAL CERTIFICATION

50123

(M)

10-1-1935

Memorandum

10-1-1935

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any special tests necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Item 20 Fill 309 3-21-62 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> Item 14 Film G309 3/20/62 1wk 03116 03106											
1. PLACE OF DEATH a. COUNTY <u>Charles</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HUGHESVILLE 104</u> c. LENGTH OF STAY IN tb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA 83X-3</u> d. STREET ADDRESS <u>Temple Trailer Village</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>STERLING FURMAN ERVIN</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-10-15</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH <u>3 11 1962</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>W. VA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>BENJAMIN ERVIN</u> 14. MOTHER'S MAIDEN NAME <u>Artie Wymer</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>343-01-9859</u> 17. INFORMANT <u>MARY ANN ERVIN</u> Address <u>ALEXANDRIA VA.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 825X DUE TO <u>FRAC SKULL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>AUTO ACCIDENT (DRIVER ALONE)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DRIVER OF AUTO WHICH</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:30</u> <u>3/11</u> <u>19 62</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hwy</u> 20f. (City or town) <u>Hughesville</u> (County) <u>Chas.</u> (State) <u>Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>E J. EDELEN</u> M.D. DATE SIGNED <u>3-11-62</u> EXAMINER'S NAME (Type) <u>E J. EDELEN</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>3/14/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>104 HILL CEMETERY</u> 22d. LOCATION (City, town, or country) (State) <u>ALEXANDRIA, VA.</u>											
23. FUNERAL DIRECTOR <u>EVERLY-WHEATLEY FUNERAL HOME</u> ADDRESS <u>ALEXANDRIA, VA</u> 24a. REC'D BY REGISTRAR <u>13 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>											

03106

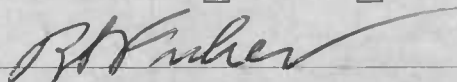
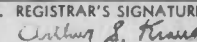


1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div> <div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>03117</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04168</div> </div> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gallant Green</b> c. LENGTH OF STAY IN b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gallant Green</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>GEORGE FORD</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>3 11 1962</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b>		<b>9. AGE</b> (In years last birthday) <b>55 ?</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days  <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country)				<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b>						<b>14. MOTHER'S MAIDEN NAME</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Stab wound of chest with penetration of lung</b> (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>dressed on wood pile. Throat slashed, compound stab wound of abdomen &amp; chest and lacerations of scalp and hands</b>									
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>3-11 19 62</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				<b>20f. (City or town) (County) (State)</b> <b>Gallant Green Charles Md.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . <b>Homicide <input checked="" type="checkbox"/></b> Undetermined manner <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME</b> (Type) <b>RUSSELL S. FISHER, M.D.</b>						<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> Address (Street, city, town, or county)  <b>DATE SIGNED</b> <b>3-13-62</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)				<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomy Board of Maryland</b>				<b>22d. LOCATION</b> (City, town, or country) (State)  			
<b>23. FUNERAL DIRECTOR</b> ADDRESS						<b>24a. REC'D BY REGISTRAR</b> <b>MAY 4 '62</b>				<b>24b. REGISTRAR'S SIGNATURE</b> 			

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*[Handwritten signature]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
03118					03107					
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rison</i>			c. LENGTH OF STAY IN 1b <i>14r</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rison</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Stanley</i> First <i>Franklin</i> Middle <i>Franklin</i> Last					4. DATE OF DEATH <i>March 19 1962</i> Month <i>March</i> Day <i>19</i> Year <i>1962</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>UNK 1879</i>		9. AGE (In years last birthday) <i>83</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co. Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>William Franklin</i>					14. MOTHER'S MAIDEN NAME <i>Not known.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Mary E. Lintneris</i> Address <i>Rison, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i> <i>2 yrs.</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Feb 1961</i> , 1961, to <i>March 19, 1962</i> , that I last saw the deceased alive on <i>March 19, 1962</i> , and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Frank A. Susan</i> M.D.					ADDRESS (Street, city or town, state) <i>Rt 1 Box 50</i>			DATE SIGNED <i>3/19/62</i>		
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>					<i>Indian Head, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-21-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>OAK GROVE CEM.</i>			22d. LOCATION (City, town, or county) (State) <i>NANJEMOY, MD.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>					ADDRESS		24a. REC'D BY REGISTRAR <i>DATE MAR 23 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	





TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03119

03108

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WALDORF</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MIRANDA</b> Middle <b>E.</b> Last <b>GARNER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>1962</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 2, 1882</b>			
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>LEMUEL WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>HOWARD GARNER, WALDORF, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-4-2 X</b> DUE TO <b>anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Denodyle Carlos Vascular Rand Alburnus Ines</b> lying cause lost. (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>12-5</b> <b>1954</b> to <b>3-26</b> <b>1962</b> that (I) (we) last saw the deceased alive on <b>3-26</b> <b>1962</b> and that death occurred at <b>5:45 A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Richard H. Dobson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. DOBSON M.D.</b>				22d. ADDRESS <b>Brandywine, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-28-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND</b>		23d. LOCATION (City, town, or county) <b>WALDORF, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, MD.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 30 '62</b>			
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

08108

CERTIFICATE OF DEATH

01119

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "NAME", "AGE", "SEX", "DATE OF BIRTH", "PLACE OF BIRTH", "CAUSE OF DEATH", "DATE OF DEATH", "PLACE OF DEATH", "SIGNATURE", and "WITNESSES" are faintly visible.]*

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

Page 4

1  
03120  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03109

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - La Plata.</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PHYSICIANS MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Guy</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Aug 1898</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY GRAY</b>		14. MOTHER'S MAIDEN NAME <b>SALLY WALLACE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-38-3371</b>	
17. INFORMANT <b>MASCELIA GRAY, LA PLATA, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory collapse</b> DUE TO <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral vascular accident</b> DUE TO (c) <b>Cerebrovascular</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 days</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes + Syphilis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2 Mar 1962</b> to <b>20 March 1962</b> that (I) (we) lost the deceased on <b>20 March 1962</b> , and that death occurred <b>11:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Wooddy</b>		22b. DATE SIGNED <b>21 Mar 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR B. WOODDY, MD</b>		22d. ADDRESS <b>LA PLATA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-23-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT REST</b>		23d. LOCATION (City, town, or county) (State) <b>LA PLATA, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt + Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
ADDRESS <b>The Hunt + Funeral Home, Waldorf, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>S. K. Kline</b>	

03100

CERTIFICATE OF DEATH

03100



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03110

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b> c. LENGTH OF STAY IN 1b <b>Indian Head</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Old Indian Head Road</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b> d. STREET ADDRESS <b>55 Elder Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS William</b> First Middle Last		4. DATE OF DEATH <b>3 10 1962</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-43</b> Yrs. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas H. Headley</b>		14. MOTHER'S MAIDEN NAME <b>Edna Edwards</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Thomas Headley-55 Elder Place</b>		Address <b>Indian Head, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRAC - BASE SKULL</b> 823X DUE TO <b>Auto Accident</b> (b) <b>Driver (Above)</b> (c) <b>Driver (Above)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>3-10-62</b> <b>3-10-62</b> <b>3-10-62</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of automobile hit a tree.</b>	
20c. TIME OF INJURY <b>7:00 a.m. 3-10-62</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Lena Hwy, Charles Co, Md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>E. J. EDELEN</b> M.D. DATE SIGNED <b>3-10-62</b> EXAMINER'S NAME (Type) <b>E. J. EDELEN</b> Address (Street, city, town, or county) <b>La Plata, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		22d. LOCATION (City, town, or country) (State) <b>Waldorf, Maryland</b>	
23. FUNERAL DIRECTOR <b>Lebanon Funeral Home, Inc.</b> ADDRESS <b>La Plata, Md</b>		24a. REC'D BY REGISTRAR <b>3-14-62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

02110

MENTAL EXAMINER'S STATEMENT OF DEATH

02110

02110



*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "The", "also", "which", "from", "to", "of", "the", "in", "on", "at", "by", "for", "with", "and", "or", "but", "if", "then", "when", "where", "how", "what", "who", "why", "how", "when", "where", "how", "what", "who", "why" are visible.]*



1  
FOR STATE  
HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03111

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WALDORF (RURAL)</u> d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First <u>DOUGLAS</u> Middle <u>H.</u> Last <u>JONES</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 6, 1956</u>	9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>EDWARD LAWRENCE JONES</u>		
14. MOTHER'S MAIDEN NAME <u>ELEANOR SWANN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		
16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT Address <u>ELEANOR JONES, WALDORF, MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7-16-0</u> IMMEDIATE CAUSE (a) <u>CONF LAGRATION</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Home borne</u>		20c. TIME OF INJURY Month, Day, Year <u>Mar 1 1962</u> Hour <u>10:30</u> a.m. <u>  </u> p.m. <u>  </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Waldorf Chas</u>		20g. (County) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>  </u> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) <u>LA PLATA, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-7-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PITTSBURG, KANSAS</u>	
23. FUNERAL DIRECTOR ADDRESS <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>					
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>					

MEDICAL CERTIFICATION

11120

MEDICAL EXAMINATION OF DEATH

08112

11120

08112

11120

11120

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03112

FOR-STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EDWARD LAWRENCE JONES</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>1</u> Year <u>1962</u>					
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JULY 1, 1914</u>	<b>9. AGE</b> (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CHEMIST</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NAVY DEPT.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>E. W. JONES</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>HALLIE JONES</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>479-03-1589</u>		<b>17. INFORMANT</b> Address <u>ELEANOR JONES WALDORF, MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>CONFLAGRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Home burned</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>10:30</u> a.m. <u>  </u> p.m. <u>  </u> <u>MAR 1</u> 19 <u>62</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. (City or town)</b> <u>WALDORF</u>		<b>20g. (County)</b> <u>Chas</u>		<b>20h. (State)</b> <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>E. J. EDELEN</u>			<b>DATE SIGNED</b> <u>3-1-62</u>				
<b>EXAMINER'S NAME</b> (Type) <u>E. J. EDELEN</u>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>LA PLATA, MD.</u>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>3-7-62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 6 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03115



2-1-60

Griffiths, G. H.

Griffiths, G. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MAY 1962											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03113											
1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> <u>RURAL</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u>					
c. LENGTH OF STAY IN b. <u>12 YRS.</u>						d. STREET ADDRESS <u>1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>JOHN BRUCE JONES</u>						<u>MARCH 1,</u>			<u>1962</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 8, 1949</u>		9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD LAWRENCE JONES</u>						14. MOTHER'S MAIDEN NAME <u>ELEANOR SWANN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ELEANOR JONES, WALDORF, MD.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>CO V FLA GRATION</u> <u>3-1-62</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Home burned</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> p.m. <u>Mar 1</u> <u>1962</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Waldorf</u> (County) <u>Charles</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. J. Edele</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>3-1-62 LA PIATA, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3-7-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PITTSBURG, KANSAS</u>				22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>HUNT Funeral Home, WALDORF, MD.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>MAR 6 '62</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kansas</u>			

01110

WILLIAM STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01110

01110

To be

GOVERNMENT

Signature



# 1

## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03125

03114

1. PLACE OF DEATH e. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WALDORF (RURAL)</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WALDORF, (RURAL)</b>			
c. LENGTH OF STAY IN lb. <b>10 MONTHS</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARK RANDALL JONES</b>			First Middle Last		4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1962</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 13, 1961</b>	
9. AGE (In years last birthday) <b>10</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>EDWARD LAWRENCE JONES</b>				14. MOTHER'S MAIDEN NAME <b>ELEANOR SWANN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>ELEANOR JONES, WALDORF, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>91680</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) <b>CON FLAGRATION</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>INTERVAL BETWEEN ONSET AND DEATH 3-1-62</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home burned</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>10:30</b> p.m. <b>MAR 1 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Waldorf Charles Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>LA PINTA, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-7-62</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) <b>PITTSBURG, KANSAS</b>	
23. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WALDORF, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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03126

## CERTIFICATE OF DEATH

Reg. Dist. No. 03115

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Charles</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>			c. LENGTH OF STAY IN 1b <b>7-Kenwood Place</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>1</b>		
3. NAME OF DECEASED (Type or print) First <b>Paul Raymond Keller</b> Middle Last			4. DATE OF DEATH <b>3-24-62</b> Month Day Year <b>19</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-1910</b>		9. AGE (In years last birthday) yrs. <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Powder Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Dixon Ill.</b>	
13. FATHER'S NAME <b>Raymond Lee Keller</b>			14. MOTHER'S MAIDEN NAME <b>Anna Baker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>USA Yes</b>		16. SOCIAL SECURITY NO. <b>213-12-1674</b>		17. INFORMANT <b>Mary Elizabeth Mrs. Bessie Keller-(Wife)</b> Address <b>#7 Kenwood Pl. Potomac Hts. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arterio-Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>4-1-50</b> , 19____, to <b>3-24-62</b> , 19____, that I last saw the deceased alive on <b>3-24-62</b> , 19____, and that death occurred at <b>3:20PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17-Potomac Ave. Indian Head Md</b> DATE SIGNED <b>3/24/1962</b>					
ACTUAL SIGNATURE <b>James E. Andrews MD.</b> M.D. <b>17-Potomac Ave. Indian Head Md</b>					
PHYSICIAN'S NAME (Type) <b>James E. Andrews MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bumpy Oak Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Pomonkey, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF MINISTER		14. SIGNATURE OF CLERGYMAN		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERMENT	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF BURIAL		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CEMETERY		23. SIGNATURE OF BURIAL		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF CEMETERY		26. SIGNATURE OF BURIAL		27. SIGNATURE OF INTERMENT	
28. SIGNATURE OF CEMETERY		29. SIGNATURE OF BURIAL		30. SIGNATURE OF INTERMENT	
31. SIGNATURE OF CEMETERY		32. SIGNATURE OF BURIAL		33. SIGNATURE OF INTERMENT	
34. SIGNATURE OF CEMETERY		35. SIGNATURE OF BURIAL		36. SIGNATURE OF INTERMENT	
37. SIGNATURE OF CEMETERY		38. SIGNATURE OF BURIAL		39. SIGNATURE OF INTERMENT	
40. SIGNATURE OF CEMETERY		41. SIGNATURE OF BURIAL		42. SIGNATURE OF INTERMENT	
43. SIGNATURE OF CEMETERY		44. SIGNATURE OF BURIAL		45. SIGNATURE OF INTERMENT	
46. SIGNATURE OF CEMETERY		47. SIGNATURE OF BURIAL		48. SIGNATURE OF INTERMENT	
49. SIGNATURE OF CEMETERY		50. SIGNATURE OF BURIAL		51. SIGNATURE OF INTERMENT	
52. SIGNATURE OF CEMETERY		53. SIGNATURE OF BURIAL		54. SIGNATURE OF INTERMENT	
55. SIGNATURE OF CEMETERY		56. SIGNATURE OF BURIAL		57. SIGNATURE OF INTERMENT	
58. SIGNATURE OF CEMETERY		59. SIGNATURE OF BURIAL		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF CEMETERY		62. SIGNATURE OF BURIAL		63. SIGNATURE OF INTERMENT	
64. SIGNATURE OF CEMETERY		65. SIGNATURE OF BURIAL		66. SIGNATURE OF INTERMENT	
67. SIGNATURE OF CEMETERY		68. SIGNATURE OF BURIAL		69. SIGNATURE OF INTERMENT	
70. SIGNATURE OF CEMETERY		71. SIGNATURE OF BURIAL		72. SIGNATURE OF INTERMENT	
73. SIGNATURE OF CEMETERY		74. SIGNATURE OF BURIAL		75. SIGNATURE OF INTERMENT	
76. SIGNATURE OF CEMETERY		77. SIGNATURE OF BURIAL		78. SIGNATURE OF INTERMENT	
79. SIGNATURE OF CEMETERY		80. SIGNATURE OF BURIAL		81. SIGNATURE OF INTERMENT	
82. SIGNATURE OF CEMETERY		83. SIGNATURE OF BURIAL		84. SIGNATURE OF INTERMENT	
85. SIGNATURE OF CEMETERY		86. SIGNATURE OF BURIAL		87. SIGNATURE OF INTERMENT	
88. SIGNATURE OF CEMETERY		89. SIGNATURE OF BURIAL		90. SIGNATURE OF INTERMENT	
91. SIGNATURE OF CEMETERY		92. SIGNATURE OF BURIAL		93. SIGNATURE OF INTERMENT	
94. SIGNATURE OF CEMETERY		95. SIGNATURE OF BURIAL		96. SIGNATURE OF INTERMENT	
97. SIGNATURE OF CEMETERY		98. SIGNATURE OF BURIAL		99. SIGNATURE OF INTERMENT	
100. SIGNATURE OF CEMETERY		101. SIGNATURE OF BURIAL		102. SIGNATURE OF INTERMENT	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information necessary, please see the instructions on the back of this form. Page 4 should be cut and forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55



Transferred to Johnson & Deakin

MEDICAL CERTIFICATION

Item 20 Filed 3/30/62											
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
03127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03116											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Charles MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 210						d. STREET ADDRESS X Marbury (Rural)					
3. NAME OF DECEASED (Type or print) First MATTIE Middle LEE Last KING						4. DATE OF DEATH Month March Day 3, Year 1962					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1940		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Charles County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Winston Posey						14. MOTHER'S MAIDEN NAME Esther King					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Esther King -Mother- Rison, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 824X DUE TO Multiple injuries extreme including (b) Structures of Skull. Right upper Extremity (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was passenger in a light pickup truck which made a left turn in the path of an oil truck coming in opposite direction, through out.							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. March 3 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt 210		20f. (City or town) Indian Head		(County) Charles	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Frank A. Susan						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank A. Susan M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 3/7/1962		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Baptist			
								22d. LOCATION (City, town, or county) Marbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Archard Funeral Home, Inc. - La Plata, Md.						24a. REC'D BY REGISTRAR DATE 7 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

DATE SIGNED  
3/3/62

Indian Head, Maryland

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF WITNESS		13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS		49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
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96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03128

03117

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAULKNER</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHARLES FAULKNER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>B.</u> Last <u>LYNCH</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>6</u> Year <u>1962</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 18, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO-RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. LYNCH</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN RUSSELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>220-32-694</u>		17. INFORMANT <u>MARGARET LYNCH FAULKNER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>15 years</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1959</u> to <u>March 1962</u> that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>62</u> and that death occurred at <u>7</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>F. M. JOHNSON</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>3-8-62</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON MD.</u>				22d. ADDRESS <u>LA PLATA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-9-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>		23d. LOCATION (City, town, or county) (State) <u>BRYANTOWN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. The attending physician and completely filled in by the funeral director, may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03117

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03118

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #6		d. STREET ADDRESS Route #6	
3. NAME OF DECEASED (Type or print) First Middle Last William Bruce Matthews		4. DATE OF DEATH Month Day Year 3 4 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marshall-Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	9. AGE (in years last birthday) 63 yrs.
11. BIRTHPLACE (County & State, or foreign country) La Plata, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Matthews		14. MOTHER'S MAIDEN NAME Jennie Stone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mr. William Bruce Matthews - Son -		Address Temple Hills Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Occlusion (c) INTERVAL BETWEEN ONSET AND DEATH 3-11-62			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/21/1962 to 3/3/1962, that (I) (we) last saw the deceased alive on 3/3/1962, and that death occurred at 11 AM from the causes and on the date stated above.			
22a. SIGNATURE E. J. Edelen M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3/5/1962	
22c. PHYSICIAN'S NAME (Type) E. J. EDELEN		22d. ADDRESS La Plata, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/6/1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery	23d. LOCATION (City, town or county) (State) La Plata, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR MAR 9 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

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Very truly yours,  
[Signature]

[Signature]  
[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
03130 03120													
1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN lb <b>1 1/2 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicans Memorial Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Monroe</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rochester</b> d. STREET ADDRESS <b>15 Navarre Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>EDWIN R. NORTHROP</b>						4. DATE OF DEATH <b>March 24, 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1903</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kodak Company</b>				11. BIRTHPLACE (State or foreign country) <b>Rochester, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>( Unkown ) Northrup</b>						14. MOTHER'S MAIDEN NAME <b>Lucie Pratt</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>Yes</b>						17. INFORMANT <b>Mrs. Anita Northrup - Wife -</b> Address <b>#15 Navarre Road Rochester 21, N.Y.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> 44 3X DUE TO <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>AUTO ACCIDENT, MINOR, AT TIME OF CVA</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HOURS</b>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>MAR 24, 1962</b>													
ACTUAL SIGNATURE <b>Robert W. Merkle</b>		EXAMINER'S NAME (Type) <b>Robert W. Merkle M.D.</b>		La Plata, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>3/28/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Rochester, New York</b>		23. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc. - La Plata, Md.</b>							
24a. REC'D BY REGISTRAR <b>MAR 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>											



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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03131

03121

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Dentsville (Rural)</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CARROLL</b> Last <b>SPALDING</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 23, 1903</b>			
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's County, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Ignatius Charles Spalding</b>				14. MOTHER'S MAIDEN NAME <b>Mary H. Norris</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. Charles Spalding - Son - La Plata, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>444X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 3-3 1954</b> to <b>3-3 1962</b> that (I) (we) last saw the deceased alive on <b>3-3 1962</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>W. Johnson</b>				22b. DATE SIGNED <b>3-3-62</b>					
22c. PHYSICIAN'S NAME (Type) <b>H. M. JOHNSON M.D.</b>				22d. ADDRESS <b>LA PLATA Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>La Plata, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arhart Funeral Home, Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

02131

CENTRE OF DEATH

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

03132

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03122

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. * If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LA PLATA Pomfret</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEN. HOSPITAL</b>		d. STREET ADDRESS <b>PHYSICIANS MEN. HOSPITAL</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS EDWARD STRAK JR.</b>		4. DATE OF DEATH Month Day Year <b>MARCH 21, 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 20, 1962</b>	
9. AGE (In years last birthday) yrs. <b>10</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>LA PLATA, MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS E. STRAK, SR.</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET WELCH.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>THOMAS STRAK, SR.</b>		Address <b>POMFRET, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - 28 wks gestation</b> 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 HRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia from 2 wks. bleeding of separated placenta</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Yeckle</b> M.D.		22b. DATE SIGNED <b>3/21/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>LA PLATA, MD.</b>		22d. ADDRESS <b>LA PLATA, MD.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/22/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>POMFRET, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>LA PLATA</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. DATE <b>MAR 27 '62</b>	

2-001596

(M)

0303

CERTIFICATE OF DEATH

03133

DECEASED

MARRIAGE

CHURCH

IN PLATE

IN PLATE

THOMAS E. STARK JR.

THOMAS E. STARK JR.

THOMAS E. STARK JR.

THOMAS E. STARK JR.

MARIED WHITE

MARIED WHITE

IN PLATE

IN PLATE

THOMAS E. STARK JR.

THOMAS E. STARK JR.

HOME THOMAS STARK JR.

HOME THOMAS STARK JR.

THOMAS E. STARK JR.

CHURCH

DECEASED

IN PLATE

IN PLATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																								
03133					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03123														
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)														
a. COUNTY <u>Charles</u>					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u>					c. LENGTH OF STAY IN lb <u>2-days</u>					d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH														
First Middle Last <u>Samuel Issachar Swann</u>										Month Day Year <u>3-23-62 3-23-62 19</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-62</u>				9. AGE (In years last birthday) yrs. <u>2</u>				IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Melvin Swann</u>					14. MOTHER'S MAIDEN NAME <u>Ruby Keys</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Mother-Ruby Swann</u>					Address <u>- Nanjemoy, Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Broncho</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper respiratory Infection</u> DUE TO (c) <u>2-Days</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-Days</u>																								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>														
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>			Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)												
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																								
ACTUAL SIGNATURE <u>James E. Andrews</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>														
EXAMINER'S NAME (Type) <u>James E. Andrews MD</u>										DATE SIGNED <u>3-23-62</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3/24/1962</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Church of Lord Jesus Christ Cemetery - Ironsides, Md.</u>					22d. LOCATION (City, town, or county) (State) <u>Indian Head, Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arehart Funeral Home, Inc. - La Plata, Maryland</u>										ADDRESS <u>La Plata, Maryland</u>														
24a. REC'D BY REGISTRAR <u>2-048549</u>										24b. REGISTRAR'S SIGNATURE <u>Arthur L. Plummer</u>														

2-048549





TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03134

03124

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WALDORF</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
c. LENGTH OF STAY IN 1b <b>LIFE</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>Z.</b> Last <b>WADE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 20, 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED BATTLES</b>		14. MOTHER'S MAIDEN NAME <b>ROSE BRAUNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MRS. CATHERINE SWANN, WALDORF, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction - at least 1 week</b> 44-3X DUE TO <b>Chronic Heart Disease at least 3 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension - at least 3 yrs</b> (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1962</b> to <b>Mar 14, 1962</b> that (I) (we) last saw the deceased alive on <b>3/4/62</b> 1962, and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>V. M. SERON MD</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3/16/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. M. SERON MD</b>		22d. ADDRESS <b>Waldorf Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-19-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST PETERS</b>		23d. LOCATION (City, town, or county) (State) <b>WALDORF, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, Md.</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>MAR 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03135

03125

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHAREES</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Indian Head</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rt 1. Box 65. Indian Head</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPH</u> First <u>ROLAND</u> Middle <u>WELCH</u> Last		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Feb 1906</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Governmt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lee Welch</u>		14. MOTHER'S MAIDEN NAME <u>Susan L. Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-8463</u>	
17. INFORMANT <u>Wife Bessie Lee Welch, Indian Head</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>2 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sent</u> <u>1959</u> to <u>March</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>2 Mar</u> <u>1962</u> and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. Wooddy, MD</u>		22b. DATE SIGNED <u>2 Mar 62</u>	
22c. PHYSICIAN'S NAME <u>ARTHUR O. WOODDY, M.D.</u>		22d. ADDRESS <u>LA PLATA, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY MEMORIAL</u>		23d. LOCATION (City, town, or county) (State) <u>WALDORF, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNT Funeral Home, WALDORF, MD.</u>		25a. REC'D BY REGISTRAR <u>6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

03152

STATE OF TEXAS

03152



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03126

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b> c. LENGTH OF STAY in 1b <b>6 Mos</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PHYS McH Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD</b> f. COUNTY <b>CHAS</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>POMFRET (Rural)</b> h. STREET ADDRESS <b>1</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUISE</b> Last <b>WILLETT</b>		4. DATE OF DEATH Month <b>3</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-04</b>
9. AGE (In years last birthday) <b>57</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b> Hours <b>19</b> Min. <b>62</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE</b>		12. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Charles County, Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Alvin Langley</b>		16. MOTHER'S MAIDEN NAME <b>Margaret Crismond</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>Unknown</b>	
19. INFORMANT <b>Mr. A. Clay Willett-Husband-Pomfret, Maryland</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.A. Uterus c Metastasis</b> 174X DUE TO (b) <b>3-7-62</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 57</b> to <b>3-7-62</b> , that (I) (we) last saw the deceased alive on <b>3-7-62</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. J. EDELEN</b>		22b. DATE SIGNED <b>3/8/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN</b>		22d. ADDRESS <b>La Plata Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 10, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc. - La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony S. Thomas</b>			

00150

(M)

CHARLES

LETT-ATA

WHP KEN

1771 Louise Willett

9-18-04

FIVE

181

C. A. Utter & Co. - 27

5-1-02

Jan 27 1902

John W. Utter

27.50000



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03137

03127

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Welcome</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Charles</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Welcome</b> d. STREET ADDRESS 			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mary Agnes</b> Middle <b>Young</b> Last 			<b>4. DATE OF DEATH</b> Month <b>3</b> Day <b>26</b> Year <b>1962</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>2/20/1901</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Joseph Smith</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Cassie Hawkins</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>I.P. Evans Welcome, Maryland</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VASCULAR ACCIDENT</b> 443X DUE TO <b>HYPERTENSIVE - ARTERIOSCLEROTIC HEART DISEASE.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PULMONARY DISEASE, RES. TB</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> <del>the</del> <sup>the</sup> (this hospital) attended the deceased from <b>9-26</b> , 19 <b>61</b> , to <b>MAR 26</b> , 19 <b>62</b> that <del>he</del> <sup>we</sup> last saw the deceased alive on <b>FEB 15</b> , 19 <b>62</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Robert W. Merkle</b>			<b>22b. DATE SIGNED</b> 		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Robert W. Merkle, M.D.</b>		
<b>22d. ADDRESS</b> <b>La Plata, Maryland</b>			<b>22e. REC'D BY REGISTRAR</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <b>3-29-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Catherine's</b>			
<b>23d. LOCATION</b> (City, town or county) <b>McConchie</b> <span style="float: right;"><b>(State)</b></span>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Montgomery Bros 719 Remedy St</b>					
<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>L.B. Montgomery</b>		<b>DATE</b> <b>54</b>			

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

APR 2 '62

Arthur L. Finney

03137

Chloroform

Graphite

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VASCULAR ACCIDENT

HEART DISEASE  
HYPERTENSION - DISTENSION

CHRONIC PULMONARY DISEASE, 12

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Investigatory Board of the Department of the Army  
Washington, D.C.